Summary of Coverage: What this Plan Covers & What it Costs

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	In-network: <b>\$500</b> Individual, <b>\$1,000</b> Family Services marked with * in Common Medical Events are not subject to deductible	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay covered services you use. Check your policy or plan document to see when the <u>deduc</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for h much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting o page 2 for other costs for services this plan covers.
Is there an <u>out–of–</u> <u>pocket limit</u> on my expenses?	Yes. In-network: <b>\$2,500</b> Individual, <b>\$5,000</b> Family Out-of-network: None	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually year) for your share of the cost of covered services. This limit helps you plan for healt care expenses.
What is not included in the out of peoplet	Premium, balance-billed charges (unless balanced billing is	Even though you now those evenences they don't count toward the out of nonloct line

What is the overall <u>deductible</u> ?	<ul> <li>\$1,000 Family</li> <li>Services marked with * in</li> <li>Common Medical Events are</li> <li>not subject to deductible</li> </ul>	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out–of–</u> <u>pocket limit</u> on my expenses?	Yes. In-network: <b>\$2,500</b> Individual, <b>\$5,000</b> Family Out-of-network: None	The <b><u>out-of-pocket limit</u></b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket</u> <u>limit</u> ?	Premium, balance-billed charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b><u>out-of-pocket limit</u></b> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network</u> of <u>providers</u> ?	Yes. For a list of <b>in-network</b> <b>providers</b> , see www.healthpartners.com/ unitypointhealth or call 1-888- 735-9200.	If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a specialist.	You can see the <b>specialist</b> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <u>excluded services</u> .

Questions: Call 1-888-735-9200 or visit us at www.healthpartners.com/unitypointhealth. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-888-735-9200 to request a copy. 32116-883064-20170101-20161002115854

1 of 8

### Coverage Period: 01/01/2017 - 12/31/2017 Coverage for: All Coverage Levels | Plan Type: PPO

Summary of Coverage: What this Plan Covers & What it Costs

- <u>Copayments</u> are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- <u>Coinsurance</u> is *your* share of the costs of a covered service, calculated as a percent of the <u>allowed amount</u> for the service. For example, if the plan's <u>allowed amount</u> for an overnight hospital stay is \$1,000, your <u>coinsurance</u> payment of 20% would be \$200. This may change if you haven't met your <u>deductible</u>.
- The amount the plan pays for covered services is based on the <u>allowed amount</u>. If an out-of-network <u>provider</u> charges more than the <u>allowed amount</u>, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the <u>allowed amount</u> is \$1,000, you may have to pay the \$500 difference. (This is called <u>balance billing</u>.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common	Your cost if you use a			
Medical Event	Services You May Need	In-Network Provider	Out-Of-Network Provider	Limitations & Exceptions
If you visit a health	Primary care visit to treat an injury- or illness	Office Visit: \$10 copay* Convenience care & MDLIVE virtual care: \$20 copay*	Not covered	none
care <u>provider's</u> office	Specialist visit	\$50 copay*	Not covered	none
or clinic	Other practitioner office visit	Acupuncture: Not covered Chiropractic: \$10 copay*	Not covered	5 visit limit for Chiropractic
	Preventive care/screening/immunization	No charge	Not covered	none
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance* for x-rays, No charge for lab	Not covered	none
	Imaging (CT/PET scans, MRIs)	20% coinsurance*	Not covered	none
If you need drugs to treat your illness or condition	Formulary generic drugs	\$10 copay* at retail \$25 copay* at Mail Order or UnityPoint Health Affiliate	Not covered	30 Day supply retail/90 day supply mail order

## HealthPartners: UnityPoint Health Network Plan Summary of Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2017 - 12/31/2017

Coverage for: All Coverage Levels | Plan Type: PPO

	what this Fran Covers & what it Costs	Your cost if you use a		in coverage Levels   Train Type, 110
Common Medical Event	Services You May Need	In-Network Provider	Out-Of-Network Provider	Limitations & Exceptions
More information about <u>prescription</u> <u>drug coverage</u> is available at <u>www</u>	Formulary brand drugs	\$30 copay* at retail \$75 copay* at Mail Order or UnityPoint Health Affiliate		90 day supply available at
.healthpartners.com /public/pharmacy/f ormularies/formular y/preferredrx/index. html.	Non-formulary generic & brand drugs	\$60 copay* at retail \$150 copay* at Mail Order or UnityPoint Health Affiliate		HealthPartners Mail Order Pharmacy and UnityPoint Health Affiliate Pharmacy
	Specialty drugs	Formulary: \$25 copay* Non-formulary: \$50 copay*	Not covered	Limited to 30 day supply per fill.
If you have	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	none
outpatient surgery	Physician/surgeon fees	20% coinsurance	Not covered	none
If you need immediate medical attention	Emergency room services	1 - 3  visits = \$100 copay + 20% coinsurance 4 - 5  visits = \$300 copay + 30% coinsurance 6  or more visits = \$500  copay + 40% coinsurance	1 - 3  visits = \$100 copay + 20% coinsurance 4 - 5  visits = \$300 copay + 30% coinsurance 6  or more visits = \$500  copay  + 40%  coinsurance	none
	Emergency medical transportation	No charge	Not charge	none
	Urgent care	\$20 copay*	\$20 copay*	none
If you have a	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	none
hospital stay	Physician/surgeon fee	20% coinsurance	Not covered	none
If you have mental	Mental/Behavioral health outpatient services	\$10 copay*	Not Covered	none

## HealthPartners: UnityPoint Health Network Plan Summary of Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2017 - 12/31/2017

<b>Coverage for:</b>	All Coverage Leve	ls   <b>Plan Type:</b> PPO
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Common	Your cost if you use a			
Medical Event	Services You May Need	In-Network Provider	Out-Of-Network Provider	Limitations & Exceptions
health, behavioral	Mental/Behavioral health inpatient services	20% coinsurance	Not Covered	none
health, or substance	Substance use disorder outpatient services	\$10 copay*	Not Covered	none
abuse needs	Substance use disorder inpatient services	20% coinsurance	Not Covered	none
If you are pregnant	Prenatal and postnatal care	Prenatal: \$10 copay* for initial visit. Subsequent visits 20% coinsurance Postnatal: 20% coinsurance	Not covered	none
	Delivery and all inpatient services	20% coinsurance	Not covered	none
	Home health care	20% coinsurance*	Not covered	100 visit limit
	Rehabilitation services	\$10 copay*	Not covered	none
If you need help	Habilitation services	\$10 copay*	Not covered	none
recovering or have	Skilled nursing care	20% coinsurance	Not covered	100 Days per confinement
other special health	Durable medical equipment	20% coinsurance	Not covered	none
needs	Hospice service	20% coinsurance	Not covered	Respite care is limited to five episodes, up to five days per episode. Inpatient hospice services are limited to 15 days per lifetime.
If your shild pasds	Eye exam	No charge	Not covered	none
If your child needs dental or eye care	Glasses	Not covered	Not covered	none
deficat of cyc calc	Dental check-up	Not covered	Not covered	none

Summary of Coverage: What this Plan Covers & What it Costs

## **Excluded Services & Other Covered Services:**

Acupuncture	<ul> <li>Infertility treatment</li> </ul>	Routine foot care
• Cosmetic surgery	• Long-term care	Weight loss programs
Dental care (Adult)	<ul> <li>Non-emergency care when travelin</li> </ul>	ng outside
Hearing aids	the U.S.	
	<ul> <li>Private-duty nursing</li> </ul>	

	• Bariatric surgery	• Chiropractic care (annual 5 visit limit)	• Routine eye care (Adult)
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### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while coverage under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-735-9200. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. You can contact your plan at **1-888-735-9200**. You can contact the Department of Labor's Employee Benefits Security Administration at **1-866-444-3272** or www.dol.gov/ebsa/healthreform.

### Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy <u>does</u> <u>provide</u> minimum essential coverage.

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage <u>does meet</u> the minimum value standard for the benefits it provides.

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-866-398-9119**. Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-888-735-9200**. Chinese (中文): 如果需要中文的帮助, 请拨打这个号码**1-888-735-9200**. Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-888-735-9200**.

**Coverage Examples** 

# About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different. Cost sharing or "Patient pays" amounts are based on self-only coverage. Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- **Plan pays \$5,620**
- Patient pays \$1,920

### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540
Patient pays:	
Deductibles	\$500
Copays	\$20
F J -	
Coinsurance	\$1,200
1 /	\$1,200 \$200

Coverage Period: 01/01/2017 - 12/31/2017

Coverage for: All Coverage Levels | Plan Type: PPO

### Managing type 2 diabetes (routine maintenance of

a well-controlled condition)

### Amount owed to providers: \$5,400

- **Plan pays \$4,280**
- Patient pays \$1,120

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400
Patient pays:	
Deductibles	\$500
Copays	\$540
Coinsurance	\$0
Limits or exclusions	\$80
Total	\$1,120

## Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from innetwork providers. If the patient had received care from out-of-network providers, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

**No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

**No.** Coverage Examples are <u>not</u> cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

**Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-ofpocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

8 of 8

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